



# Evaluation of the Rehabilitation Medicine Community Outreach Team: Lincolnshire

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## Executive Summary

The Rehabilitation Medicine Service within United Lincolnshire Hospitals NHS Trust (ULHT) has been running an expanded Community Outreach Team service since November 2014, operating from 4 locations across the county. The expansion aimed to provide an equitable service across Lincolnshire, minimise hospital admissions and ensure patients received a timely discharge back to their homes from the Specialised Rehabilitation Unit. In order to help determine the future of the service ULHT approached the University of Lincoln to conduct an evaluation involving patients, stakeholders and staff.

The expansion of the team appeared to be leading to an increased service across the county and ensuring that it was more equitable across Lincolnshire. Patients were very positive about the time that the team spent with them and the support they received. This was reflected by staff feeling more able to deliver a good quality service to their patients with improved response times and a wider range of therapies available. The benefits of home visits was also stressed by patients, staff and stakeholders. Some patients also talked about the wider impact the service had had on their quality of life.

Stakeholders interviewed had good working relationships with the Outreach Team and communication with patients and carers was positive. There were some issues raised around the team's name and a re-branding, along with promotion to both stakeholders and patients, may be required.

The majority of patients had only been using the service for the past few months and were unable to comment on any changes which may have occurred since the expansion had taken place. However some stakeholders provided anecdotal evidence that the team were able to deal with more referrals from them and that community admissions to Ashby ward had decreased, however there may be additional factors associated with this.

Staff unanimously agreed that they were now able to provide a better service to patients although they felt communication between the four sites and the way in which data is collected and stored by the Outreach Team both required further improvement.

Overall the evaluation found the Rehabilitation Medicine Community Outreach Team were a very successful team and held in high regard by both their patients and the stakeholders they liaised with.

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## Introduction

The Rehabilitation Medicine Service within United Lincolnshire Hospitals NHS Trust (ULHT) is currently delivered from a specialised rehabilitation unit (Ashby Ward) at Lincoln County Hospital, outpatient clinics at Lincoln County, Grantham and Pilgrim Hospitals and satellite clinics in Louth, Gainsborough and Bourne. In addition to this the Rehabilitation Medicine Community Outreach Team had operated, until recently, from Lincoln and Grantham Hospitals, each having a full time nurse, part time Occupational Therapist and part time Physiotherapist.

The inpatient service on Ashby Ward had achieved the British Society for Rehabilitation Medicine (BSRM) standards, however the Community Outreach Team standards were not fully met and ULHT therefore identified a need to increase the capacity of this service with the aims of:-

- Meeting the BSRM standards
- Ensuring patients received a timely discharge from the Specialised Rehabilitation Unit, or tertiary centre, back to their homes.
- Providing specialist support to patients living in the community with Long Term Neurological Conditions to minimise hospital admissions.
- Ensuring equity of service across Lincolnshire.

It is ultimately hoped to offer a full 7 day Community Outreach service across the county, however initial expansion has provided a 5 day service from 4 locations. This included teams based at Boston and Louth in addition to the original sites of Lincoln and Grantham. Each site has an Occupational Therapists (OT), Physiotherapist and Clinical Nurse Specialist as well as additional OT and Physiotherapy Assistants where required. A Dietician and Speech and Language Therapist to cover the whole county were also included.

This enhanced service was initiated during November 2014 although some posts in the Boston area were not filled until the first part of 2015 and the Senior Speech and Language Therapist post remains vacant. Funding is currently available until March 2016 so ULHT have asked the University of Lincoln to conduct a process evaluation to examine the views of service users, stakeholders and staff to help determine the future of the service following that date.

The process evaluation commenced during June 2015 with the final report completed by November 2015. A Steering Group from ULHT, including the Clinical Lead for Therapies and Rehabilitation Medicine and members of the Rehabilitation Medicine Community Outreach Team met with the evaluation team regularly throughout the evaluation. Throughout the report the Rehabilitation Medicine Community Outreach Team is often referred to as the Outreach Team for ease of reading.



## 2.0 Methodology

### 2.1 Applying for ethical approval

An application was made on 29<sup>th</sup> June 2015 to the Research Ethics Board in the School of Health and Social Care at the University of Lincoln. Prior to submission the form was also shared with ULHT for comments and agreement. The ethics application was approved on the 6<sup>th</sup> August 2015. Copies of the application and approval letter are included in Appendix 1.

### 2.2 Aims and objectives of the evaluation

The primary aims of the evaluation were:-

- To examine the views of service users by analysing data from the Patient Experience Survey and opinions obtained during focus groups.
- To compare current views of patients with those from a previous Patient Experience Survey conducted during 2014.
- To explore the views of key stakeholders and determine their experiences of the new initiative using in-depth interviews.
- To identify any strengths and weaknesses, including good practice, occurring across the initiative.

### 2.3 Methods

The evaluation used a range of data collection methods including patient questionnaires, focus groups, in depth interviews with stakeholders and a staff survey. The use of each of these is further outlined below.

#### 2.3.1 Patient experience survey

A patient experience survey had previously been conducted by Ad-esse Consulting as part of a wider review of the rehabilitation services in Lincolnshire in early 2014. At that time a total of 400 questionnaires were randomly distributed to patients discharged between January 2012 and December 2013 and 86 were returned - a response rate of

22%. Results from this survey were available and, to enable comparisons to be made, it was therefore decided that this evaluation would use the same questionnaire.

The patient database was used by ULHT to identify all patients seen by the service between November 2013 and July 2015. A total of 968 patients were identified. A random sample of 400 of these patients was then selected with 250 from the North database and 150 from the South database. This split was approximately representative of the number of referrals in each area. ULHT distributed questionnaires by post and enclosed a stamped addressed envelope so that questionnaires were returned directly to the evaluation team. The questionnaire also included an additional question asking whether the participants would be willing to take part in subsequent focus groups. If in agreement they were asked to include contact details on their returned questionnaire. Responses were input to a computer package (SPSS) in order to analyse responses.

A copy of the questionnaire and letter are shown in Appendix 2.

### **2.3.2 Patient focus groups**

A semi-structured topic guide was developed, in conjunction with the Steering Group, for use with the patients. The topic guide aimed to explore in more depth the areas initially covered by the questionnaire, including any changes that patients may have noticed since the expansion of the service. The topic guide is included in Appendix 3.

Four focus groups were organised and conducted by a Site Lead Occupational Therapist with a member of the evaluation team present. One group took place in each of the new Outreach Team areas as follows:

- 12<sup>th</sup> October, Louth
- 13<sup>th</sup> October, Lincoln
- 14<sup>th</sup> October, Boston
- 15<sup>th</sup> October, Grantham

All those who provided contact details on the questionnaire were sent a letter by ULHT inviting them to take part in a focus group. Due to the nature of patients' conditions the Steering Group felt that participants should be provided with a topic guide, information sheet and consent form prior to the focus group (included in Appendix 4). This would enable them to prepare their responses in advance if required.

### 2.3.3 In depth interviews with stakeholders

A semi-structured topic guide was developed, in conjunction with the Steering Group, for use with the stakeholders. The topic guide aimed to examine how the stakeholders worked with the Rehabilitation Medicine Community Outreach Team including any examples of good practice and how this working relationship may have changed since the changes to the Outreach Team had taken place.

A copy of the topic guide is included in Appendix 5.

Contact details for 14 external stakeholders were provided to the evaluation team by the Steering Group. All stakeholders were contacted by email or telephone and final interviews conducted with 13 of these:

- MND Regional Care Development Advisor, East Midlands
- MS Nurse Specialist ULH
- Consultant, Rehabilitation Medicine, ULH
- Speciality Doctor, Rehabilitation Medicine, ULH
- Consultant Rehabilitation Medicine ULH
- Consultant Neurologist, ULH
- Information and Support Worker, Headway Lincolnshire
- Physiotherapist, MS Centre, Lincoln
- Occupational Therapist, Adult Social Care, Lincolnshire County Council
- Case Manager for Sleaford Medical Group
- Case Manager for Marisco Medical Centre, Mablethorpe
- Matron, St Barnabas Hospice, Grantham
- AHP Lead, St Barnabas Hospice, Lincoln

Interviews took place at a location agreed with the stakeholder between the 22<sup>nd</sup> September and 13<sup>th</sup> October 2015. In general this was either the stakeholder's place of work, or on University premises.

Prior to the interview commencing all participants were provided with further background information about the study and reassured that participation was voluntary and that they could withdraw at any stage should they wish to do so. They were then asked to read and sign a consent form (included in Appendix 6).

Interviews lasted between 30 and 70 minutes with between 20 and 55 minutes being digitally recorded conversation which was transcribed verbatim.

No personal information appeared on any of the transcripts, only unique ID codes were used. The data transcriptions were password protected and printed versions were stored in a locked filing cabinet on the university premises.

#### **2.3.4 Staff survey**

30 staff within the rehabilitation team, including managers, were emailed an online questionnaire directly from ULHT to ask their views of the enhanced Rehabilitation Medicine Community Outreach Team service. Questions included whether there had been any positive or negative changes since the start of the enhanced service as well as any suggestions for improvements to the current service or opportunities for future development. Members were also asked whether they had been a team member prior to changes and if they had any line management responsibilities.

Completed electronic copies of the questionnaires were sent directly to a member of the evaluation team. A full copy of the questions is shown in Appendix 7.

## 3.0 Results

### 3.1 Results of patient consultation

A total of 123 responses were received to the questionnaire, a response rate of 31%. Of those responding 86% were patients and 14% were carers. Similarly, in the first patient experience survey conducted during 2014, 89% were patients and 11% were carers. Three separate responses were also received in the form of letters or notes appended to the questionnaire. These required individual responses and were therefore passed back to the Clinical Lead for Therapies and Rehabilitation Medicine.

In addition to the questionnaires a total of 13 participants also attended focus groups across the 4 locations. Of these 9 were patients and 4 were carers – 2 of whom attended with the patient and 2 who attended on behalf of the patient. Themes from the questionnaire and focus groups were grouped and the following key areas identified:

#### 3.1.1 General experience of the Outreach Team

Patients responding to the questionnaire and attending the focus groups were generally very positive about the service they received from the Outreach Team. They valued the time that the team spent with them and the level of support they received:

*I never have the feeling that they rush through something. I really feel like we are the most important at that time. Whatever needs to be covered they just spend the time. And that's wonderful. And you know they just listen.*

*It's personal, it's private, they have time and I relax and I think it comes down to the interpersonal skills of the people. I think very highly of them and (team member's name) very good at steering the conversation so she gets the information out of oneself she needs and you wouldn't get that in a 6 minute interview at doctors. And I personally feel it builds up a friendship. With friendship comes trust and trust is so important.*

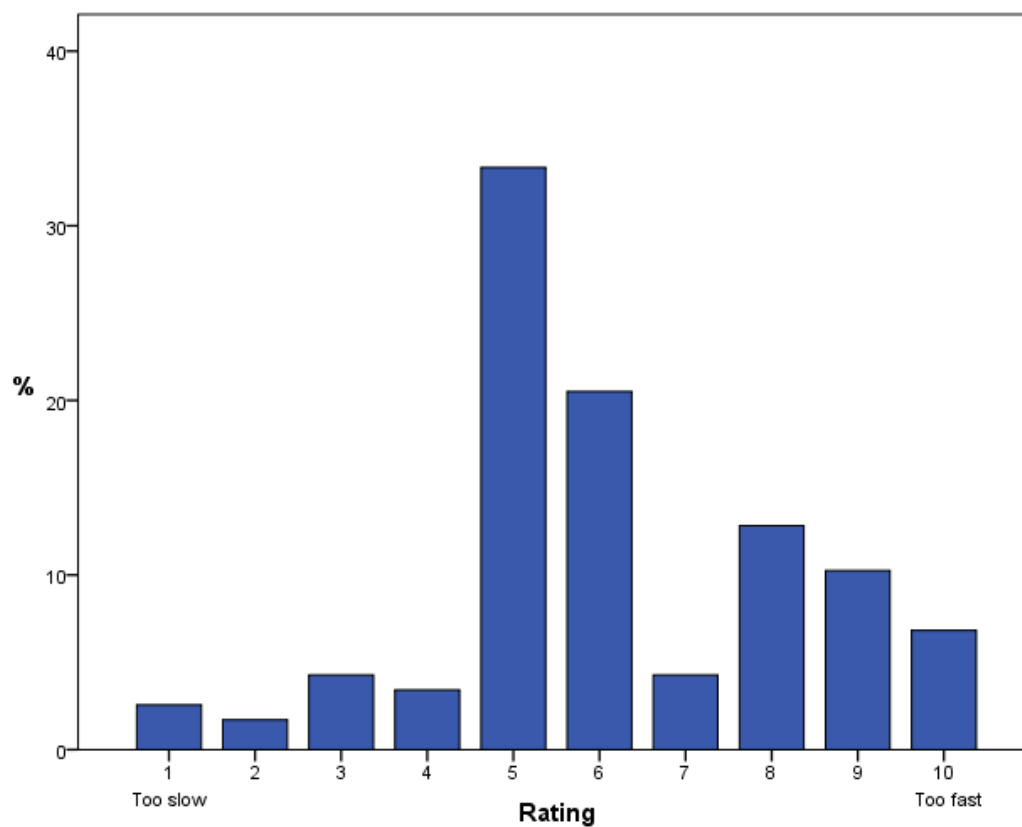
*I've just enjoyed the process. To me it's a luxury. Somebody coming to my home and doing exercises with me. Talking through what you are doing and then you look forward to them coming again. It, its an amazing service. You just don't get that in other places.*

*Living out in a village, I could have felt very isolated but didn't due to the wonderful support I received. Ten out of ten.*

*Very happy this service has been commissioned. Not feeling isolated any more. Now have a life line when needed. Staff very professional, helpful and friendly.*

Respondents to the questionnaire were also asked whether the pace of treatment they received was too slow, too fast or just right. Figure 1 highlights that over half of respondents (52%) rated the pace as being 'just right' with a 5 or a 6.

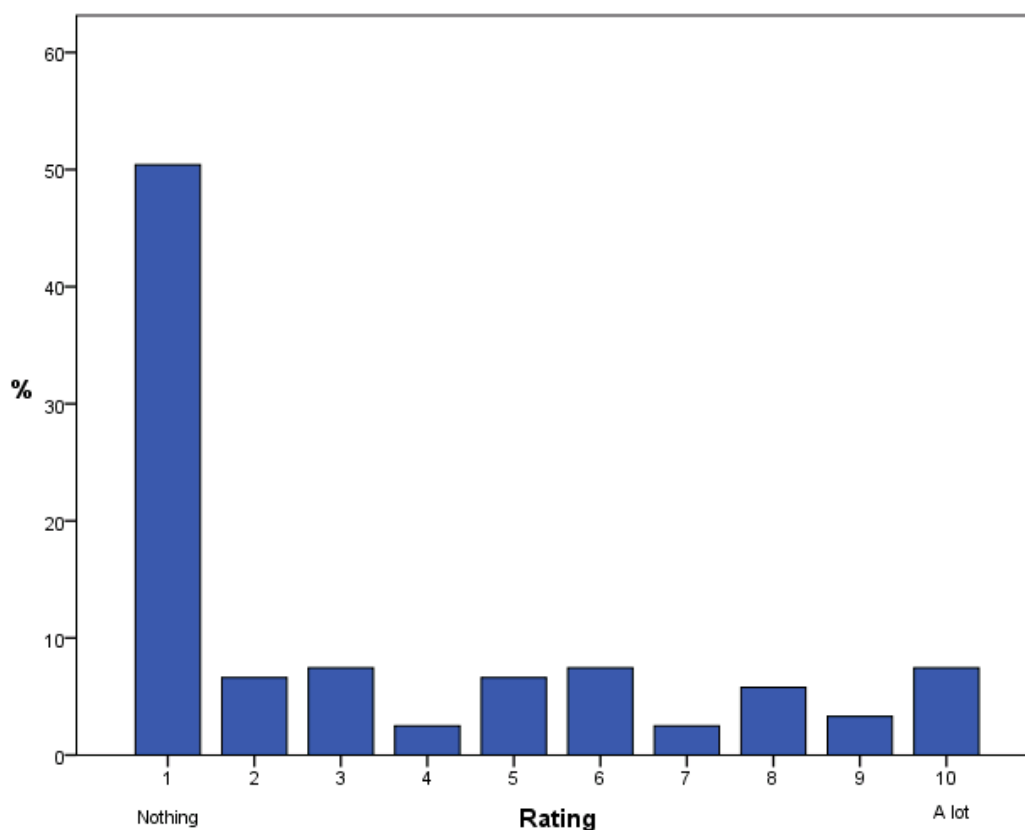
**Figure 1: Was the pace of treatment too slow, too fast or just right?**



### 3.2.2 Referral to the service and knowledge of the team

Half of the respondents (50%) to the questionnaire reported knowing nothing about what the team did before being seen by them (Figure 2).

**Figure 2: How much did you know about what the team does before being seen by them**



However, once treatment had begun 42% of patients responding to the questionnaire stated that the therapist had 'completely' explained to them about what the team does.

Survey respondents were asked how quickly they were seen after being referred. 27% reported that they were seen very quickly, an increase of 7% from the survey in 2014. Furthermore participants were also asked to rate how easy it was to contact the team after they were first seen by them. Nearly four in ten (38%) reported that it was very easy. Finally, the survey asked how easy it was to organise seeing the therapists/nurses at

home or at the clinic. Again four in ten (40%) reported that it was very easy, an increase of 8% since 2014.

A number of patients in the focus groups had been referred to the Outreach Team through their GP or directly from the hospital consultants and were happy with the process and length of time it had taken. However, one patient who had suffered a traumatic brain injury, rather than having a neurological disease such as MND or MS, had been unaware of the service until an external stakeholder provided them with information and other respondents to the questionnaire felt information on discharge from hospital would have been helpful:

*What I would say is disappointing is the referral was from an external source – the (external stakeholder). At no point in hospital, at the GP stage or afterwards up until I jumped did anybody come knocking on the door and say that they understood that I'd had a brain injury and this is the help they can give me. Until I stepped back and said that I couldn't cope. (External stakeholder) said to leave it with them. And now I am in the system absolutely fine.*

*We should have been made aware of this service when the patient was discharged from hospital, in fact it would have been most helpful if therapy sessions had been organised at that point*

Once patients knew about the service the majority were aware that the people they saw were part of a wider team:

*It's been very clear for me from the beginning it's a team because when (team member's name) would visit we would go through exercises and then (another team member's name) would visit and do some mindfulness with me and stuff that would help me relax. And she knew everything that had gone before from (team member's name). So they knew what each other was doing. And it was like an extension.*

*I think it's a team. We saw (team member's name) and (team member's name) at the first meeting. And they were talking about the team that they can get back to. Talk to the other people that were involved. They get the basics and then they will discuss with us and others how they can support (patient). So it is definitely a team.*



However, in a number of cases the patients appeared to have surmised this themselves rather than being provided with any official information informing them:

*When I started the physio side I realised as you get letters and stuff that they've all got the occupational heading on it. So that there was obviously more than one person.*

There was also an assumption among some patients that other health professionals who provided care in the home were also from the same team. For example one individual had assumed the Speech and Language Therapist was part of the Outreach Team because she also visited them in their own home and had been organised by a member of the Team. Ironically the team had hoped to recruit a Speech and Language Therapist as part of the expansion, but had been unable to do so. In some cases patients were happy that they knew enough about the team from the letter they were initially sent on referral, but, other patients felt they would have liked further written information about the team and how they linked together.

*I would have liked is an A4 sheet with photo of each member of the team and a brief overview. I'm blah, blah that kind of thing. I think I still have good grasp on memory but others may not. I think it would be useful to have an overview... the whole puzzle would become a picture. Not just pieces.*

*I think you need to have someone give you those leaflets. I don't mind admitting I got a bit confused. There was the OT. And then there was outreach and I was getting people mixed up. Because there were so many people involved.*

### **3.2.3 Communication with the team**

Overall 43% of respondents thought the nurse or therapist had assessed their condition very well and a similar proportion of respondents felt that they were well informed throughout the therapy they received (44%) (Figure 3). This was an increase of 9% since the survey was conducted in 2014 when only 35% of patients felt well informed. A slightly lower proportion of patients (36%) felt that the nurse or therapist had completely explained what they would achieve with their therapy, however this was still an increase since 2014 (29%).

**Figure 3: How well informed were you throughout your therapy with this team?**

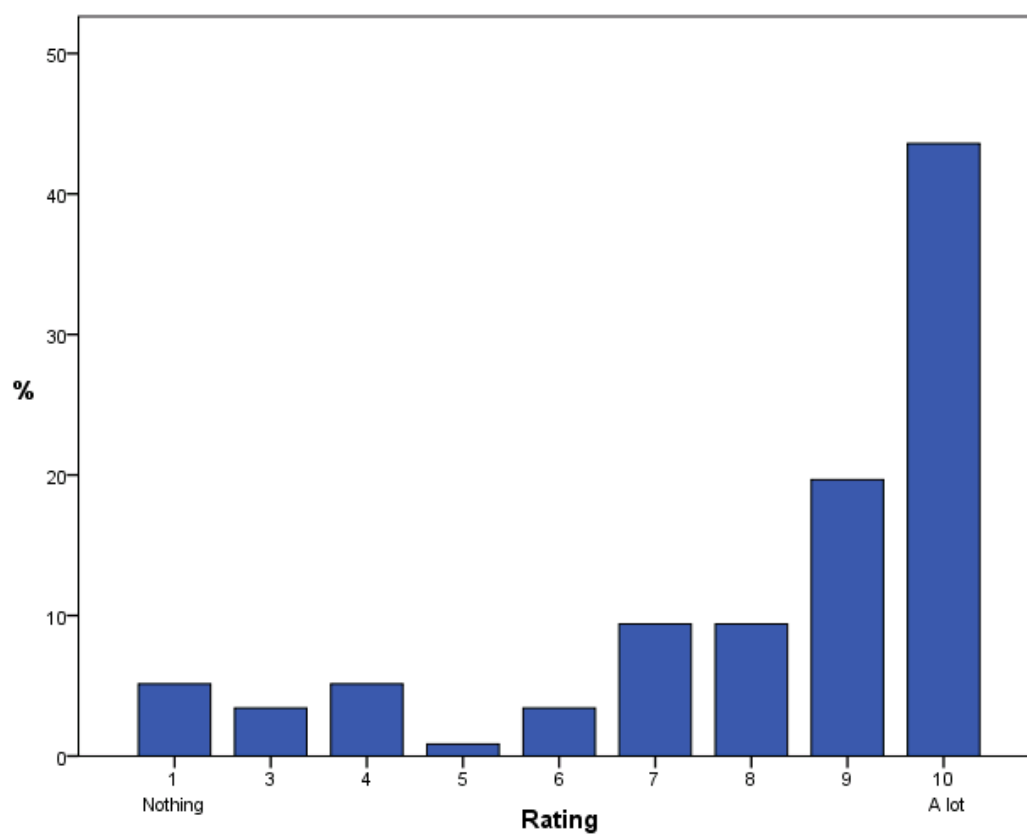
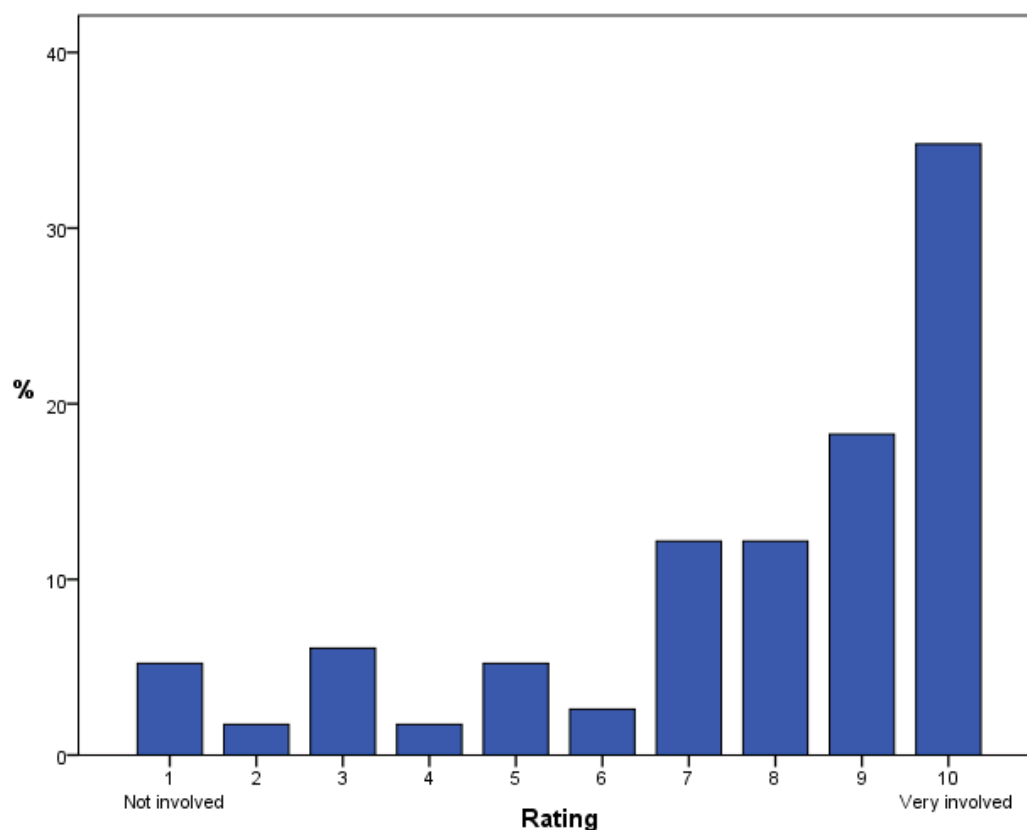


Figure 4 shows that over a third of patients (35%) reported feeling very involved in setting their goals with a further 30% rating this as 8 or 9. This was an increase of 6% from the 2014 survey.

**Figure 4: How involved did you feel in setting goals for your treatment?**



Overall patients were satisfied with how easy it was to communicate with members of the Outreach Team. A number of patients reported that they had been left a mobile number or email address so that they could contact a team member directly and this personal service was certainly valued by patients:

*She's always kept in touch and I've got her number and I've always been able to get hold of her*

*To be honest we really have had good communication. They have helped us through decisions. Whatever has been said has been communicated with us. And we felt it's helped us make better decisions.*

*If you are just ringing a department it's very difficult. If you've got one vocal person and she will ring back. That's very important.*

There did however appear to be a lack of consistency in whether patients were provided with phone numbers or email addresses of the staff and one patient who had been provided with only phone numbers thought it would be '*very handy to have an email*'. In another case a patient also mentioned having to leave a phone message, and that it would be '*nice if there was a voice at the end of the phone*'. However, they then did acknowledge that their message had always got through and been acted upon. One respondent to the questionnaire also stated that they continued to receive letters despite being blind.

The regularity of communication from the team, even when not requested by the patient, was also appreciated:

*But the great thing about them is that somebody rings me. About once every six weeks and says "How are you doing and do you need anything?" That's wonderful... it's like a dream team!*

One patient even mentioned that this regular contact meant she sometimes didn't contact her GP, but waited for her next visit from the Outreach Team:

*And even though my condition appears to be quite stable, they are coming every three months. So if you are having a bad day, rather than just reach for the GP you think "Oh, she is coming back in a few months" and then the next day you are a lot better and off you go*

Communication with the Outreach Team wasn't restricted to patients, but also extended to carers. All those carers present in the focus groups talked about being included in any discussions, whilst those patients present also mentioned that their partners had been included by the Outreach Team if required:

*They have included us in everything and as a carer, we very often get left out. I have been involved in every step. They ask my opinion on what would help. It makes a nice change.*

*And they don't just take notice of what I say. They are very good with hubby. He's not always at home and they come when he is. I just think they are excellent.*

### 3.2.4 Facilitating links

In addition to being satisfied with the accessibility of the Outreach Team, patients also acknowledged that communication between team members was good:

*They talk to each other. They are a team. So they all know what's going on.*

*They often say "Oh I saw so and so and I'll mention this" ... they very much speak to each other.*

As well as working with other rehabilitation members of staff a number of patients also mentioned the benefit of working with other stakeholders and their knowledge of other services which may be available:

*The best thing (team member's name) did was to introduce me to the Red Cross. I never knew what they did. They are fantastic.*

*It's that feeling of security. Makes you feel much safer. All the things that they've introduced me to or suggested have added to that feeling that I can go to somebody. It's a go to service.*

However respondents to the questionnaire highlighted that in some cases the response from the other organisation had been slow or they were still waiting:

*Still waiting to hear from social services about extra time for caring and respite.*

*Wheel chair services very slow waited 10 months for new chair to be delivered.*

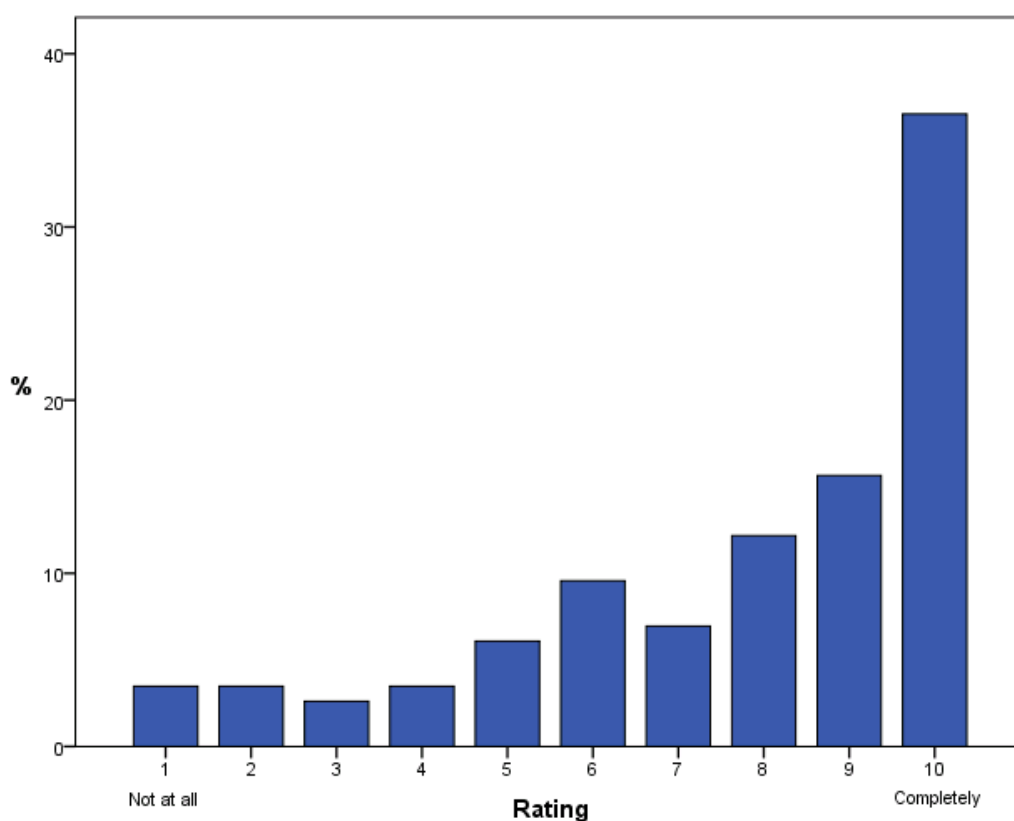
The only issue raised with regards to links with other stakeholders was that level of contact between specialist centres in hospitals and local services such as the Outreach Team with some patients feeling they had to take it upon themselves to make sure they passed on communication from different areas of the health service:

*It's just confusing and stressful. You have to be on top of it as well to make sure everybody has the same information*

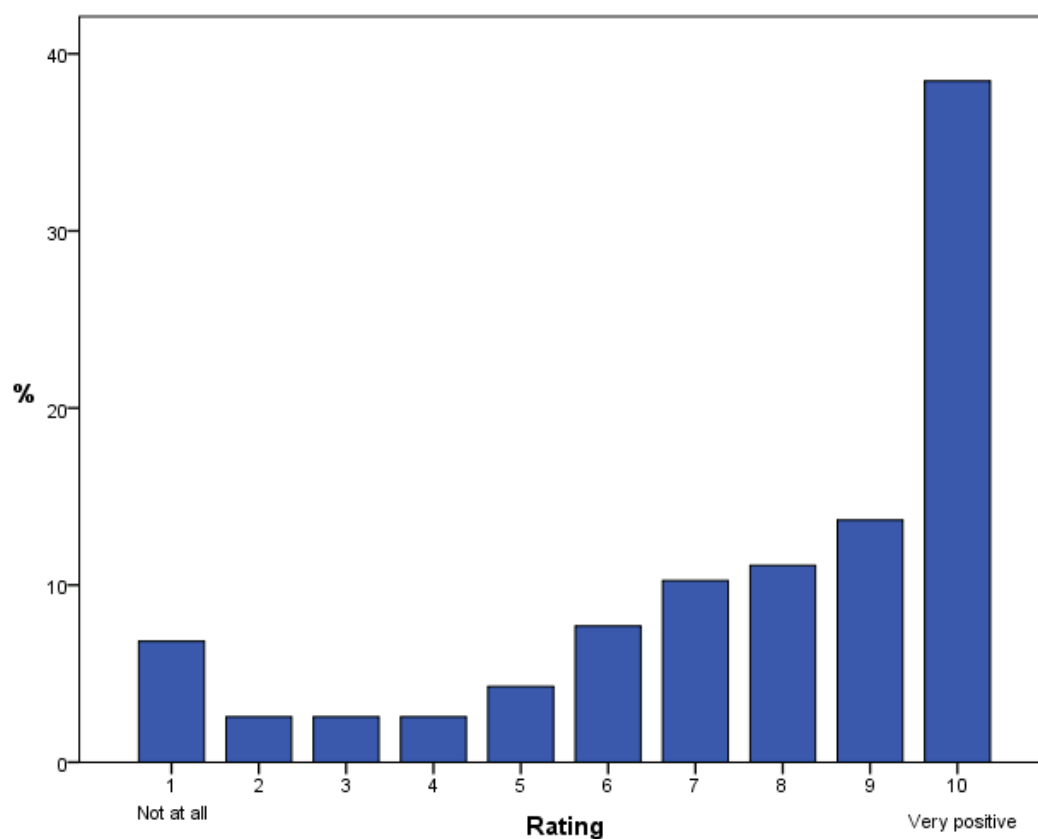
### 3.2.5 Impact on quality of life

Respondents to the questionnaire were asked how well the service fitted around their personal life. Almost half (45%) reported that the service completely fitted around their personal life with a rating of 10, an increase of 9% from 2014. In addition the survey aimed to ascertain whether the service met the respondent's needs. Figure 5 shows that nearly four in ten (37%) felt the service completely met their needs with a further 28% giving a rating of 8 or 9.

**Figure 5: To what level did the service meet your needs?**



Furthermore, the survey asked respondents about the level of support they received. The results indicate that almost four in ten (37%) felt they had received the right level of support rating it as 10 out of 10. Finally, respondents were asked how much of a positive impact the service had on their life. Figure 6 highlights that nearly four out of ten (39%) respondents reported that the service had a very positive impact. This was an increase of 7% from the survey in 2014.

**Figure 6: How much of a positive impact has the service had on your life?**

A number of patients within the focus groups talked about the impact the Outreach Team had had on their quality of life. In some cases this was a very general comment about the impact of the team, but in others it was due to the provision of specific information about equipment which was vital to a patient's needs or the expertise of the Outreach Team with regards to the treatment being provided:

*You guys stepping in was life changing and it's allowed me to get back on track.*

*We are living in an older cottage which is really hard to adapt but we had some very good suggestions. We have it all now re-done to a standard we can now live a normal life. (Name omitted) suggested a company supplying walking, climbing wheelchairs that I have never heard about.*

*I was talking to a gastroenterologist and telling him that my gut was not working properly and he said it was just irritable bowel and then I saw the Outreach Team*

*and they said 'Oh that's really common and we'll just give you this'. It was absolutely wonderful.*

This assistance was not restricted to physical items or help, but also extended to the mental wellbeing of patients:

*The emotional support is very good as well. Your emotional wellbeing is so important when you are in pain and if you don't feel you can cope with it.*

As well as improving their general day to day living some patients talked about the wider impact the service had had on their lives and the lives of those around them. In one case the patient felt the support from the Outreach Team had enabled her to return to a more normal family and work life whilst in other cases it had eased the worries carers had about long term provision for adult children they were caring for:

*It has been huge. I had to give up work due to the difficulties I was having. I was driving a great deal and had a lot of mechanical difficulties around my spine and neck. And my legs. When she started coming I wasn't even able to get down a step. I was walking to the left, dragging my leg. I'm now walking upright. Shoulders back. No neck pain. I have core strength now.... It's changed my life with my family. I'm thinking of going back to work. It's changed my family life because I'm more awake. More aware. I've come off medication. The pain is so reduced. It's like getting my old self back. We are now working on me getting on a bike. I would never have thought in my wildest dreams. I can't praise them enough*

*One of my main concerns was if something was to happen to me at home like I collapsed. What would we do? And at first I rang social services and they sent me a red ticket that I keep on my house key which gives my neighbours number. But since then we've moved on with (team member's name). We have talked about what would be possible. Rather than just be thrust into a ward with very poorly people. I would prefer for him to be looked after at home. So (team member's name) has helped find out how this would be possible.*

*The outreach team does help because of their experiences and what they can give her (the carer's daughter). And also it does help me as well because it helps me to move away from that constant caring role. We are finding that that is quite*

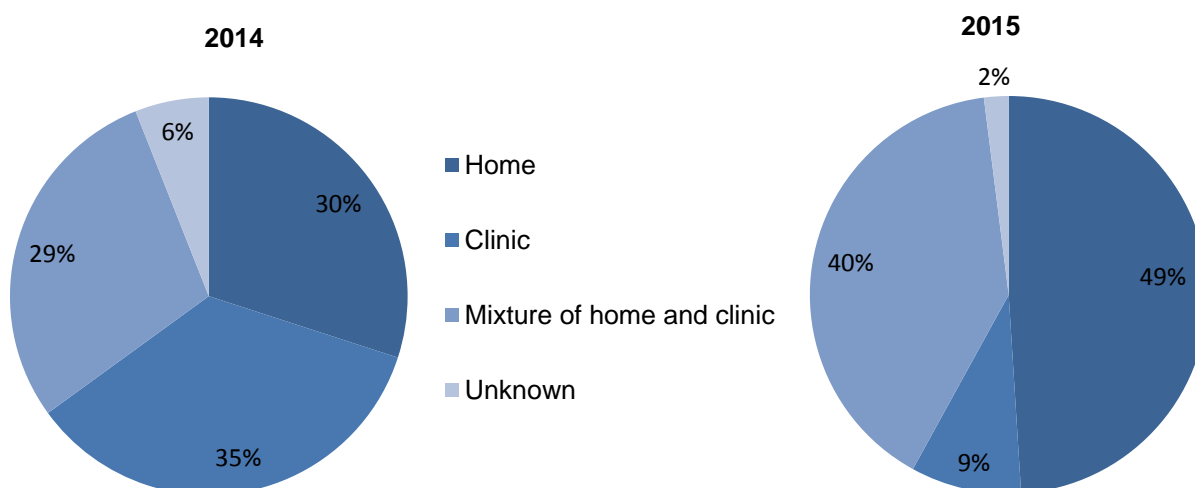


*important. For my daughter to mix with other people. She's doing cooking with her and things like that. To actually do that with someone else is nice for my daughter to socialise and interact with somebody else.*

### 3.2.6 Value of being seen in their home

Figure 7 highlights that there was a substantial increase in respondents reporting that they were seen by the team at home with almost half (49%) in the most recent survey selecting this compared to only 30% in the 2014 survey. Furthermore, only one in ten (9%) respondents reported being seen by the team in the clinic compared to just over a third (35%) in 2014.

**Figure 7: Where were you seen by the team? (2014 survey n=86, 2015 survey n=123)**



The value of being seen in their own home was clear from all patients within both the qualitative survey and focus groups. As well as the Outreach Team being able to assess them in their own environment there were other advantages ranged from the physical benefit of not being so tired from travelling elsewhere to the emotional benefits of feeling more relaxed and less stressed all of which may help them engage with their treatment:

*The fact that you haven't got to be up, out and dressed at a certain time.  
Somebody that will come to the home is just great. That's where we spend all our*

*time. For them to see us in our surroundings then the tips that they give is brilliant. It's vitally important that they come out and see home circumstances.*

*I find it invaluable. It makes me feel comfortable. Like I've got time. That I'm not rushed. That I can talk about things. And because I lie down on the floor and do the exercises and it takes effort and I wouldn't necessarily want to be in a room like this doing it. You feel safe.*

*With MS you get fatigued and you come back from the appointment and all you want to do is sleep. Whereas if somebody comes out to your home like the team does then you can welcome them in and put the kettle on and then do the necessary*

*I think (patient's name) has more confidence that way. He was able to talk more. Be able to explain and feel in a safe environment to do that.*

This view was also supported by carers one of whom explained how getting to hospital was also a stressful experience for her:

*For me also travelling to the hospital. Finding parking. Getting the wheel chair out. Finding our way round. Getting there. It changes us. I'm not relaxed.*

Despite the positive aspects of being seen in their own home one member of the focus group did state that for their physiotherapy sessions they had enjoyed visiting the clinic:

*I want to go out otherwise I could have stagnated and gone inwards.... It makes me go out and do something*

However they did also acknowledge that if they had been less mobile a home visit would have been beneficial.

### **3.2.7 Changes to the team**

The majority of focus group participants had only been using the service for the past few months and were therefore unable to comment specifically on any changes which may have occurred, whilst the few participants who had been using it for longer had not noticed any significant changes.

It is difficult to determine whether any of the new patients would have been seen prior to the expansion, had they required it, or whether they have only been seen recently due to the expansion. However, one lady in an area with a newly formed Outreach Team had only recently been referred to them earlier this year despite having a long term neurological condition:

*After ten and a half years in the doldrums, it has actually been wonderful.*

### 3.3 Results of stakeholder interviews

A total of 13 stakeholders were interviewed. 5 of these were members of the medical staff from Lincoln County Hospital who worked with the Outreach Team, 3 of whom were based within the Rehabilitation Department. The remaining 8 were stakeholders representing external organisations working across Lincolnshire.

Following the interviews five themes were identified as follows:-

- Awareness of the Outreach Team and their expansion
- Joint working with stakeholders
- The impact of the expansion on patients
- Maintaining patients in the community
- Impact of reducing the Rehabilitation Medicine Community Outreach Team

#### 3.3.1 Awareness of the Outreach Team and their expansion

The stakeholder names were all provided by the Clinical Lead for Therapies and Rehabilitation and, as would be expected, all those interviewed had therefore worked with the Rehabilitation Medicine Community Outreach Team. However, not all stakeholders could identify the team from its full name, and in one organisation the email inviting them to participate in the evaluation had been passed amongst staff before one member recognised which team it referred to:

*I wasn't aware of the name, I'm aware of some people in it, but not the name.*

*She bounced it to me saying "Do you know who this team is?" and I read it and thought the only team I could think of that it might be is the team that we have*

*always called either the Long Term Conditions Team or, more recently, the Community Outreach Team.*

Another stakeholder referred to the team throughout as the “*Neuro Outreach Team*” and a further one did not recognise the team name at all, but knew she had worked with the “*Outpatient Rehab Team*”. Others struggled with the full name even when they were aware of it:

*I heard of the Rehab-, Reha-, Rehabilitation Community Outreach Team.*

*Let me get my terminology correct here... Rehabilitation Medita... Medical... Medicine Community Outreach Service.*

*Yes, I think it's the medicine bit I find confusing. If it was the Community Outreach Rehabilitation Team I would probably have got it, but the medicine bit there was a bit confusing.*

In general stakeholders were clear about when they would approach the Outreach Team to be involved with one of their patients although they weren't always aware of the full range of services offered through them. One stakeholder talked about one of her patients requiring suction and how she had learnt, almost by accident, through another patient that this service was available through the Outreach Team. Similarly stakeholders were not always aware that certain members of staff were actually part of a wider team. This was particularly true of the new dietician's post. This was mentioned on more than one occasion, but appeared to be thought of as being separate from the rest of the Outreach Team:

*She's also offered her team's support so her physio and OT to work with ours on those specific sessions and she's got a contact from a dietician who will come and support us as well so it's, that, that's been really helpful.*

In terms of changes to the team, those stakeholders who worked directly with the team through Ashby Ward at Lincoln County Hospital were all aware of the expansion as were a few of the other stakeholders. However, in some cases stakeholders were aware that there had been changes, but not exactly what those changes were.

Providing more information about the team and their role was also an area picked up when stakeholders were asked what further improvements the team could make.

*Improving the knowledge of other sectors of the NHS, you know, Social Services, District Nurses, GPs, the rest of the acute care, you know, nobody seems to know much about rehabilitation medicine and I think if we promoted ourselves better then we would be used better.*

In some cases awareness sessions had been planned with stakeholders to address these issues:

*I asked (team member's name) if she would come and address the OTs in our area so that our team and the other team that do Lincoln, because a lot of them didn't know what they did and that was really useful in terms of networking and I think that is something that should be done more of.*

*They photocopied a map for me... I'm aware that, that's where the arms of this, of the OT area and they're in kind of 4 corners and (team member's name) was explaining all that to me.*

*(Team member's name) did actually, was coming over to one of our meetings. She had a plan to come over and talk to us about this team at one of our team meets, but that never happened and actually that would have been quite beneficial for the whole team to see what they were.*

### **3.3.2 Joint working with stakeholders**

Despite the confusion over the name of the Outreach Team once stakeholders knew the individuals involved they were all very positive about their working relationships and felt there were no barriers to working with the team:

*I just think they're a brilliant team that work brilliantly to improve the lives of anybody with neurological conditions and without them, the lives of these people would, not be as, I'm trying to think how to word this, would not be as, promising and, well basically they just improve the lives of people with debilitating conditions to the best of their abilities.*

*Invaluable, collaborative, I think if we weren't working together neither of us could do our job properly.*

*They are experienced, they're helpful, they're kind people who will look for solutions with you rather than saying "yes, we don't do that"... The Outreach Team are just a joy to work with. They've just got all the bits you want when you are another service trying to refer a patient, you know, trying to get something for the patient.*

*Very professional team, very knowledgeable, very good working relationship, kind of a joined up service for people who have been diagnosed with, horrible diseases,*

There appeared to be considerable cross referral of patients between stakeholders and the Outreach Team, therefore ensuring that patients had access to the full range of services available to them. The Outreach Team also undertook joint visits with other stakeholders, or were involved in multi-disciplinary teams (MDTs) and the expansion of the teams was enabling them to undertake more of this work. One specific example of this was joint work being undertaken with St Barnabas and the Parkinson's Nurse to develop an 8 week patient information programme for patients with neurological illnesses. This would help provide a range of information to patients about their condition followed by disease specific sessions and finally the development of a personal health plan. Signposting in this way was identified as a gap by other stakeholders during this work and the expansion of the Outreach Team will enable both physios and OTs to work on specific sessions to deliver such a programme.

### **3.3.3 The impact of the expansion on patients**

Some stakeholders had not been in post long enough to have worked with the Outreach Team prior to the expansion and therefore could not comment on how the changes had impacted on the referral rate, but in other cases, stakeholders provided anecdotal evidence that the team were able to deal with an increased number of referrals:

*There was always a feeling that previously their capacity was so limited that we were always conscious of how many referrals we were doing, trying to divert away from the team into, if we could, outpatients, for example, or directly back to district nursing and... that wasn't always the best thing to do because sometimes patients do need that level of speciality and, so it has, not given us a free reign is*

*the wrong word, but it's made us be able to be more, more able to refer directly into the team where we feel it's been needed.*

*I've definitely noticed that they've had more capacity. They sometimes used to ring us, (team member's name) would ring me to say "This patient really needs seeing, we just can't. We don't have the ability to see them. Could you possibly see them? I know really we should be seeing them, but we can't" and that is happening less. Definitely, they, it's possibly even happening more the other way. I'm definitely more aware that there is more capacity on their side than there used to be. Yes, definitely.*

However, although stakeholders generally reported feeling more able to pass patients onto the Outreach Team, one did report that the expansion had led to a higher number of people being referred back to them which had increased their workload.

*Yes, the referrals have increased now that more of the OTs are aware of (organisation's name) and its services. The referrals have definitely increased.*

A number of stakeholders mentioned the size and rurality of Lincolnshire and how the new team structure would enable a more equitable service to patients across the county:

*If you live in Boston or if you live in Lincolnshire there isn't a postcode lottery thing going on you've got the same knowledge because they pool their knowledge and they support each other with that knowledge that it feels like people are going to get an equitable service across the county which is really important*

*Because Lincolnshire is rural and semi-rural and it's a thinly spread population across a big patch so I think this hub model works well and I think the four hubs are, I think at the minimum required, four hubs. You can always have more, but these four hubs are good... I've got another impact because if you save on time and you have a local service you get more input as well. If the team has to come from 20 miles and then go back 20 miles you're lucky if you get you know a few contacts, especially if you are not having a very urgent need or your condition is not progressing right? So you are having less contact, you'll have some telephone contact, but less of the individual kind of you know hands on contact or assessment, but if your team is local then you get more of it.*

There were a number of examples provided by stakeholders where the Outreach Team had been key in providing services which had made a massive difference to the quality of life of their patients. In one case the expertise of a member of the Outreach Team prevented the patient from having further surgery:

*I can think of a lady that, (team member's name) and I saw her in our spasticity clinic who had, had some surgery done, and got seen by the surgical team and, because she was having more problems with her walking, developing spasticity ended up having all sorts of MRIs and things like that because they didn't know what was going on and then (team member's name) comes in and it's basically like her expertise and it's basically she's got some spasticity and needs her gait re-adjusting and now the lady's life is completely different you know she can walk better, she's active, you know it just makes such a difference just that little bit of specialist knowledge to tweak things or make things better and to be fair if that had happened before she'd seen the spinal surgeons she wouldn't have had to go through any of that so, you know, it's just those, it really does make a difference having that level of specialist team out there.*

In other cases it has been long term work with patients that have improved their quality of life. In one case a member of the Outreach Team had spent time with a lady who had become house bound following a head injury and little by little had encouraged her to go from not being able to leave the house to being able to go out and about on her own.

In another a member of the team had persisted in writing letters to consultants and surgeons on behalf of a patient who required surgery:

*The Outreach Team pushed for this surgery to happen and the woman is now standing, able to stand with a stand hoist and I saw her the other day and I've not seen her for months and, she, she was telling me "I can stand up now (respondent's name), I can actually stand with the stand hoist and I don't have to be hoisted onto a toilet, I don't have to poo in a pad, I can go onto my commode" and it's made a massive, massive difference to her life..... and I know it's (team member's name) and, who wrote the letters because I saw the letters myself that Ashby was writing the letters to the consultants and the surgeons saying that if she has this surgery and does this it'll make such a massive impact on her life.*



Obviously impacts such as these require the Outreach Team to spend a considerable amount of time with each patient and stakeholders commented on how hard the team worked to enable this level of service to be provided:

*I know they stretch themselves during the day trying to, trying to squeeze in as many patients as they can.*

### **3.3.4 Maintaining patients in the community**

One of the aims of the expansion of the Outreach Team was to maintain patients in the community rather than them being admitted, or re-admitted, to Ashby Ward (the neuro-rehabilitation ward at Lincoln County Hospital). There was anecdotal evidence collected from the stakeholders that community admissions to the ward had decreased:

*I do think admissions, our community waiting list, has definitely reduced and the number of community admissions... we've gone from a couple of years ago there was something like 28 admissions from the community in one year and over the past couple of years it's been down to about 5 so there has been a significant reduction*

*Well there have been changes definitely because now hardly we have any community patients*

However, it is difficult to attribute this purely to the increase in the Outreach Team as other changes had also occurred, for example the recognition of the role of rehabilitation following major trauma means patients being moved into Ashby Ward following treatment in other hospitals as well as patients being moved there following admission through Lincoln's A and E ward. However, a number of external stakeholders also mentioned that the Outreach Team tried their best to maintain patients in the community even if they couldn't comment directly on a reduction in admissions to Ashby Ward:

*So hospitalisation, touch some wood, on our currently clients that we share have been quite good because obviously if there's a problem with breathing then (team member's name) goes straight out because they have special equipment so it has kept them at home which is what we're looking at.*

*I think a lot more stuff is being done, being done on an outpatient basis and support going on at home so yes, I would say yes, I would have noticed that yes,*

*I know there's one particular chap with MND we've shared between us and I know he's had a couple of very bad, negative experiences, admissions to hospital and we, we, we do share, you know to try and support this guy at home to stop chest infections and stuff to keep him at home. So we would definitely work together to avoid that, I mean I wouldn't have figures, as to, we certainly try to work together to keep patients out of hospital.*

It was felt that once the Outreach Team could be more engaged in the discharge planning process once patients were due to be discharged from Ashby Ward. However, it was acknowledged that the current lack of joint working in this area was not purely down to the Outreach Team:

*There still does seem to be a little bit of loss of communication, and, and I don't mean that's necessarily down to the team as such, I think that's maybe, because of the way, we work in acute care...I feel we could work more closely with the Outreach Team from Ashby Ward we, we always have, we have key worker meetings for patients on Ashby and I think if we involved the Outreach Team more in the discharge planning process so that they were more aware of what we were heading for and referrals were made at that point into the rehab Outreach Team then they would be able to pick them up when they needed to.*

### **3.3.5 Impact of reducing the Rehabilitation Medicine Community Outreach Team**

Stakeholders were asked to comment on what would happen if the Outreach Team was not available to patients, or the service was once again reduced. All were clear about the potential negative effects this would have:

*I think that if it was contracted and made smaller it would be derogatory for those patients in this area.*

*I think that the patients, whatever they get now is going to go down the drain, they will be at potential risk of coming to hospital, potential risk of injuries, of not having the support and their care need will increase eventually, they will come with more health problem and hospital admission and more injury to themselves actually because there is nobody to direct them.*

*That would be very fragmented you know it would be communication with a separate sub departments of rehabilitation, for example physio, occupational*

*therapists you know, Social Services and so on and that would be very distracting .... They are actually, it's like an intermediary, they are always close to the patient as the first point of the, kind of contact.*

One stakeholder also commented that they would “*probably be badgering the consultants more for information*” so there may also be some benefit in external stakeholders contacting experienced members of the Outreach Team and therefore freeing up the time of other staff members.

### 3.4 Results of staff questionnaires

A total of 22 responses were received from staff members. 6 of these were from managers, 5 from team members employed prior to the expansion and 11 from members employed as part of the expansion.

#### 3.4.1 Improvements since the expansion

Staff were initially asked to comment on any positive changes they had noticed since the start of the enhanced service. Those who had previously been involved in the service, both managers and team members, unanimously felt that they were now able to provide a better service to patients. This included spending more time with patients, giving them more regular treatments and providing additional therapies which it had not previously been possible to give:

*I feel better in that we can offer a better service to our patients and can work with them towards their goals in practical activities e.g. accessing community activities which I did not have any capacity to do before.*

*I am able to see people more regularly than they were seen before and have had some positive feedback on the benefits of them having regular treatment particularly maintaining range of movement with regular stretches and exercises.*

*The ability to provide rehabilitation for patients that require 2 pairs of hands, previously treatment sessions were limited by only having a single therapist therefore there is more scope for progression.*

One of the main reasons given for improvements to the service was the benefits of being divided into 4 teams which each had a smaller geographical area to cover:

*OT having to cover such a large area which resulted in spending so much time travelling in the car. This means I can give a better service to my own area patients.*

*Less time travelling across county... previously it could take 90 minutes to reach a patient due to the size of the area covered.*

*Less travel due to new team now covering Louth area.*

Responses from the team members who had been recruited following changes also supported the views of more established members of staff with reports of improved patient satisfaction with respect to the service being provided and how they can access the service:

*Patients are also reporting a high level of satisfaction with regards to the speed of access to the service and the on-going support they are able to receive.*

*Good feedback from patients who have reported being seen in their own homes is less stressful and vastly more convenient as they have severe mobility difficulties or the journey time to and from hospital increases their fatigue levels.... Good feedback from patients who have been able to self-refer back into the service. More convenient than going through the process of GP appointments with followed chain of referral.*

*I have heard comments that clients felt supported and that the services has enhanced part of their life.*

### **3.4.2 Challenges since the expansion**

Respondents were also asked about any challenges or negative changes they had been aware of since the expansion. The issues raised were varied, from the not being able to recruit to some posts and the challenges of new management responsibilities to some staff feeling that patients were still excluded as they didn't meet the service criteria. However the main key themes that arose were around the team structure and administration.

Two members of staff had noted that they felt there was a more cohesive team feel in their area, but there were a number of others who stated that the team felt disjointed now that it was spread across four teams and that the ‘*feel of the team is lost*’.

*I feel the teams have become very fragmented and everyone seems to be going off and doing “their own thing”*

*Difficulty with continuity across all 4 teams due to different managers*

*Only negative change is that four teams all have their own managers on their own site.... A bit disjointed.*

There were also comments around patients not being aware that staff were part of a wider team and the impact this may have on how quickly services are delivered to them:

*I sometimes feel when I visit patients at their homes they are not aware that I am part of the “Outreach Team”.*

*Patient’s often do not relate to the different health care professionals as being from one team, instead they see us as working separately, therefore they will not always mention issues they are having, which they feel is not your speciality, meaning there is a delay in these being dealt with, when actually a message could be passed on much quicker if they viewed us more as a team, than separate specialities.*

One other area where staff felt there had been challenges was with respect to administration and in particular data input

*The database still requires manual input and as much as I would like to rely on this it does not tally with the clinical manager detail or what the team are telling me.*

### **3.4.3 Future improvements and developments**

Staff were given the opportunity to offer suggestions for improvements which, in an ideal world, could be made to the current service or any opportunities for future development. A number of the points raised relate back to the changes and challenges discussed above.

### Team structure

A number of the suggestions for improvement related to the structure of the team, and in particular additional posts which staff felt may improve the service offered. These suggestions included the need for a single manager, which reflected the views outlined above that the team now felt less joined up, as well as the need for additional specialist posts:

*There are several professional leads involved in Outreach. A specific Outreach Clinical Team Leader may enable a more consistent way of working for all professions across all sites.*

*To have more therapy support to allow a more intensive follow up post hospital discharge.... I feel this would be particularly beneficial for patients discharged from Ashby Ward who go from a very intensive therapy to, at present, a markedly reduced service.*

*Consider other skills that are needed in the service i.e. long term neurological patients often have respiratory issues at end of life and a Respiratory Physiotherapy specialist would be an asset to the team. There is no service for these patients.*

Some staff felt that more regular meetings either within the outreach areas or across the county as a whole may help with communication and sharing skills:

*Maybe everyone could get together a bit more and discuss ideas/problems and keep everyone in the 'loop'.*

*More team meetings within the areas outreach service to discuss client issues or pass over especial (sic) those with conditions like MND to ensure they are being seen regularly and meeting targets.*

### Administration

Staff reported a number of challenges around administration. For some this related to the difficulties of being based across more than one site whilst others felt the standalone database the team use was time consuming and the paper based system used by the Outreach Team felt outdated compared to other community services. Staff reported that

these issues impacted on their time and also affected the awareness and knowledge of the team by other health professionals:

*Feel the database takes up a lot of time and could possibly be made simpler.*

*Most other health and social care teams are on SystmOne and are often not aware that we are involved.*

*Access to SystmOne would allow a much more integrated service with other community services particularly GPs, Speech and Language, community nurses and community palliative care teams. It would also limit the duplication of documentation, reports and referrals.*

Some staff felt simply having additional administrative support would help:

*Or could this be delegated to an admin member of staff as it does impact on my clinical time.*

*More administration support to be available across the sites as it is difficult to have the time for admin and to access the admin support.*

### **Marketing the Service**

There were a number of comments around the marketing and branding of the Outreach Team. Some staff felt that there needed to be more promotion of the team both internally and externally to provide people with further information about what the team are able to do. Others felt that having something which identified them all as part of a team would enable people to identify them more easily, and also provide a better service:

*Better branding of Outreach Team/team identity to ensure patients awareness of team clearer*

*The use of something distinctive to highlight us as members of the Outreach Team, such as badges or uniforms would help patients identify us as one team rather than separate health care professionals which would then allow us to provide more joined up care for them.*

## 4.0 Limitations and Conclusions

### 4.1 Limitations

The patient survey response rate was reasonable at 31%, however this may still not have reflected the views of all users of the service. Although results were available from the first survey conducted in 2014 it was difficult to make any detailed comparisons as full details of how responses had been coded during Survey 1 were not available.

The number of people attending the focus groups was disappointing and may have implications on the responses received. The short timescale meant some people who had expressed an interest in wanting to attend had been unable to and it may be that in future it would be helpful to allow more time for organisation or provide another opportunity for those not able to attend to put their views across.

Participants in the focus groups and stakeholder interviews were often unable to comment on changes to the service since the expansion. A larger scale, longer term evaluation may have enabled both patients and stakeholders to be identified who had specifically had experience before and after expansion.

Due primarily to time limitations contacts for the interviews were provided by the Clinical Lead Therapies and Rehabilitation Medicine and responses from them may therefore be biased since they were already using the service. Had further time been available additional respondents could have been pursued who may not currently work jointly. In a number of interviews issues were raised around the knowledge of GPs regarding rehabilitation medicine and they may have been an interesting group to pursue further had time and finances allowed.

### 4.2 Conclusions

Overall the evaluation found the Rehabilitation Medicine Community Outreach Team were a very successful team and held in high regard by both their patients and the stakeholders they liaised with. The expansion of the team appeared to be leading to an increased service across the county and ensuring that it was more equitable across all areas. This was reflected by staff also feeling more able to deliver a good quality service to their patients.



#### **4.2.1 Delivery of the Service**

The evaluation highlighted improvements in the delivery of the Outreach Team's service within the community. Participants felt response times had improved, there was more time being spent with patients during home visits and a wider range of therapies were now available. Although evidence is purely anecdotal it is highly likely that all of these benefits are due to the increase in staffing and in particular the addition of two new sites of delivery in Boston and Louth.

It was difficult to assess whether the Outreach Team had had an impact on admissions or re-admissions to Ashby Ward. Some evidence was provided during the stakeholder interviews that this was the case, but further investigation of admissions data and waiting lists would be required to provide hard evidence of this.

The benefits of home visits was stressed by the majority of patients, stakeholders and staff. They enable therapists to see patients in context of own home rather than in the superficial clinic setting and ensure patients are relaxed and stress free. One patient did prefer to visit the clinic so that they were still getting out and about and it may be that, wherever possible, there needs to be a choice in where rehabilitation services are provided.

#### **4.2.2 Communication with patients and stakeholders**

Overall patients were happy with the level of communication and carers felt that they were included in discussions where necessary.

The stakeholders interviewed all had good working relationships with members of the Outreach Team, however they had been selected to be part of the evaluation due to current links with them. More communication may therefore be required to other health staff to ensure they all know about the team, the services they offer and their target audience e.g. GPs, district nurses. Such information could explain the geographical divisions, team structure, the services available and that the team assists those with traumatic brain injury as well as degenerative diseases such as MND and MS. This would enable the Outreach Team to work more closely with other areas of health provision and may lead to future cost savings. For example patients seeing the Outreach Team rather than making GP appointments and stakeholders approaching the Outreach Team for information rather than consultants.

#### **4.2.3 Promotion of the team**

In addition to some lack of knowledge about what the team does there appears to be considerable confusion among stakeholders about the team name and any structural changes that had taken place since the expansion. In some cases stakeholders failed to recognise the team from its full name of Rehabilitation Medicine Community Outreach Team. It may therefore be necessary to consider re-branding the team to ensure all stakeholders can relate to it.

Providing patients with a brief leaflet with information about the team and its members may also help promote the team and ensure patients are aware of the full range of services available. This would be particularly useful for those patients who are suffering some degree of memory loss due to their illnesses or injuries. It may also help patients contact the team as soon as they need them so that interventions can be put in place as soon as possible before they reach crisis point. In the long term this may help reduce admissions to Ashby Ward and could provide a potential cost saving.

#### **4.2.3 Internal staffing and systems**

Staff raised some issues with regards to management of the teams across the county and a lack of communication between sites since the expansion. Communication between the sites may therefore need to be reviewed and additional team meetings or an additional post to oversee the sites considered so that they do not become four fragmented teams.

Not all staff included in the original expansion plans had been employed, for example a Speech and Language Therapist, and the final staff member was not recruited until May 2015. These recruitment difficulties were particularly pronounced in the Boston area. This may have meant that the impact of changes due to the team were not as great as they could have been had all vacancies been filled and all staff been in post since November 2014 when initial changes took place.

A number of staff mentioned the current database system for storing patient information was difficult and time consuming to use. Some suggested the need for additional administrative support for this or suggested the use of a computer package called SystmOne which is currently used by other community health workers to enable information to be shared more freely. The way in which data is collected and stored by the Outreach Team is vital to the delivery of the service and may therefore need some

attention to help staff maintain their records and also provide evidence for any future funding bids the team wishes to undertake.

## Appendix 1: Ethics application and approval letter

# EA2

## Ethical Approval Form: Human Research Projects



This form must be completed for each piece of research activity whether conducted by academic staff, research staff, graduate students or undergraduates. The completed form must be approved by the designated authority within the Faculty.

**Please complete all sections.** If a section is not applicable, write N/A.

<b>1 Name of Applicant</b>	Dr Ros Kane Department: School of Health and Social care
<b>2 Position in the University</b>	Principal Lecturer
<b>3 Role in relation to this research</b>	Principal Investigator
<b>4 Brief statement of main Research Question</b>	<p>Funding has been secured from United Lincolnshire Hospitals Trust (ULHT) to conduct a process evaluation over a six month period of the expansion of the Rehabilitation Medicine Community Outreach Service being implemented across Lincolnshire.</p> <p>The primary aims of the evaluation are:-</p> <ul style="list-style-type: none"> <li>• To examine the views of service users by analysing data from the Patient Experience Survey and opinions obtained during focus groups.</li> <li>• To explore the views of key stakeholders and determine their experiences of the new initiative using in-depth interviews.</li> <li>• To identify any strengths and weaknesses, including good practice, occurring across the initiative and inform decisions about its future delivery.</li> </ul> <p>A full report covering all aspects of the research will be prepared for the United Lincolnshire Hospitals Trust.</p>

## 5 Brief Description of Project

The Rehabilitation Medicine Service within United Lincolnshire Hospitals NHS Trust is currently delivered from a specialised rehabilitation unit (Ashby Ward) at Lincoln County Hospital, outpatient clinics at Lincoln County, Grantham and Pilgrim Hospitals and satellite clinics in Louth, Gainsborough and Bourne. In addition to this the Rehabilitation Medicine Community Outreach team operate from Lincoln and Grantham, each having a full time nurse, part time Occupational Therapist and part time Physiotherapist.


The inpatient service on Ashby Ward had achieved the British Society for Rehabilitation Medicine (BSRM) standards, however the Community Outreach team standards were not fully met and ULHT therefore identified a need to increase the capacity of this service. It is ultimately hoped to offer a full 7 day Community Outreach service across the county, however this initial expansion provided a 5 day service from 4 locations (Boston, Louth, Grantham and Lincoln) with the aims of:-

- Meeting the BSRM standards.
- Ensuring patients received a timely discharge from the Specialised Rehabilitation Unit, or tertiary centre, back to their homes.
- Providing specialist support to patients living in the community with Long Term Neurological Conditions to minimise hospital admissions.
- Ensuring equity of service across Lincolnshire.

This enhanced service has now been running since August 2014 and funding runs out in December 2015. The have therefore asked the University of Lincoln to conduct a process evaluation to examine the views of service users and stakeholders to help determine the future of the service.

Stakeholders to be interviewed will include staff at all levels within the service e.g. rehabilitation medicine consultants, occupational therapists and nurses, as well as external partners e.g. GPs, district nurses, MND Regional Care Development Advisor Headway, MS Society. Their views of the current service will be examined against the BSRM standards which the Community Outreach team are striving to achieve. Interviews will be tailored to each of the participants, but will cover topic areas such as:-

- The coordination of the Rehabilitation Medicine Community Outreach team
- Links between the Outreach team, inpatient facilities and other external stakeholders
- Benefits the stakeholders see the service offers to patients
- Gaps in provision
- Improvements/good practice since the expansion
- Any further improvements which could be made with the level of resource available.



Focus groups will be carried out with a selection of patients organised by the Community Outreach team. Discussions will examine their views of the new service and, if they were patients prior to the service expansion, will consider any changes they have seen. An outline for patient focus groups is also included in Appendix A.

The process evaluation will be conducted start during June 2015 with a final report to be written by the end of the pilot project.

	Approximate Start Date: June 2015	Approximate End Date: November 2015
<b>6 Name of Principal Investigator or Supervisor</b>	Dr Ros Kane	
	Email address: rkane@lincoln.ac.uk	Telephone: 01522 837326
<b>7 Names of other researchers or student investigators involved</b>	Jane Deville, Research Assistant, UoL David Nelson, Research Assistant, UoL Carol Duff, Senior Lecturer and Occupational Therapist UoL	
<b>8 Location(s) at which project is to be carried out</b>	Lincolnshire (ULHT sites).	
<b>9 Statement of the ethical issues involved and how they are to be addressed –including a risk assessment of the project based on the vulnerability of participants, the extent to which it is likely to be harmful and whether there will be significant discomfort.</b>  <b>(This will normally cover such issues as whether the risks/adverse effects associated with the project have been dealt with and whether the benefits of research outweigh the risks)</b>	<p><b>The Ethical issues for this study which have been considered are as follows:</b></p> <p>Interview process:</p> <p>Participants will take part on a completely voluntary basis and will be required to give informed consent prior to the interview process commencing. Following the reading of the Participant Information Sheet they will be asked to complete and sign the Participant Consent Form immediately before the interview or focus group. The Participant Information Sheet and Consent Form are both attached in Appendix B.</p> <p>It will be made clear to participants prior to the interviews that they are entitled to decline to answer any specific questions, and are free to withdraw at any stage of the process, with or without reason. It is estimated that the interviews will last approximately 60 minutes. Participants will be informed that they may terminate the interview at an earlier point, should they feel uncomfortable at any point. The opportunity to ask any questions will be given to participants both before and after the interviews have been carried out. It will be made clear to participants that if at any point they are unhappy with anything regarding the study, they are free to express this and will not be penalised for doing so.</p> <p>Great effort will also be made to reassure participants that strict confidentiality will be upheld at all times throughout the research process. Specifically, all data collected by the research team will be made anonymous prior to the interviews being analysed and reported on. Any digital recordings will be transcribed as soon as possible and any identifying information will be removed. After transcription the digital recordings will be wiped clean. This method should enable participants to answer honestly and openly during the interviews, by assuring that anonymity and confidentiality will be maintained throughout the research process.</p>	

	<p>All data relating to the fieldwork will be stored in a locked metal filing cabinet and on a password protected PC at the University of Lincoln, Brayford Campus. Only the research team will have access to the participants' personal data.</p> <p>It has also been recognised that individual participants (hospital staff members) may feel concerned or uncomfortable during the interview process about raising any negative opinions and thoughts. Therefore, efforts will be made to hold the interviews away from the immediate work environment, in a convenient, relaxed, private and comfortable space.</p> <p>Focus groups:</p> <p>The above ethical issues will also be considered for the focus groups and participants will be given copies of the Information Sheet and Consent Form included in Appendix C. In addition copies of the following guidelines will be given to all participants and read out to the group prior to the discussions taking place.</p> <ul style="list-style-type: none"> <li>- Everyone must treat each other with respect.</li> <li>- Discussion needs to stay on the topic</li> <li>- People should speak one at a time</li> <li>- Everyone needs to listen (even when disagreeing)</li> <li>- People can leave if they don't feel comfortable</li> <li>- Any responses given will remain confidential and must not be discussed outside of the group</li> </ul>
<b>10 Does this research require the approval of an external body?</b>	<p>No – as it is evaluation so does not require formal NHS R&amp;D approval – but we will inform the R&amp;D department at ULHT and ensure we have the correct permissions to analyse their secondary data and interview the staff.</p>
	<p>If "Yes", please state which body:</p>
<b>11 Has ethical approval already been obtained from that body?</b>	<p>Yes <input type="checkbox"/> -Please append documentary evidence to this form.          No <input type="checkbox"/> N/A</p> <p>If "No", please state why not:-          Please see notes in section 10 above.</p> <p>Please note that any such approvals must be obtained and documented before the project begins.</p>



	Participants will also be reminded at the end of the focus group that they should respect each others privacy and not reveal the identities of other participants or discuss who made any specific comments during the focus group discussion.
<b>10 Does this research require the approval of an external body?</b>	No – as it is evaluation so does not require formal NHS R&D approval – but we will inform the R&D department at ULHT and ensure we have the correct permissions to analyse their secondary data and interview the staff.
	If “Yes”, please state which body:
<b>11 Has ethical approval already been obtained from that body?</b>	Yes <input type="checkbox"/> -Please append documentary evidence to this form. No <input type="checkbox"/> N/A
	If “No”, please state why not:- Please see notes in section 10 above.
	Please note that any such approvals must be obtained and documented before the project begins.

**APPLICANT SIGNATURE**

I hereby request ethical approval for the research as described above.  
I certify that I have read the University's ETHICAL PRINCIPLES FOR CONDUCTING RESEARCH WITH HUMANS AND OTHER ANIMALS.

\_\_\_\_\_  
**Applicant Signature**

\_\_\_\_\_  
**Date**

\_Ros Kane\_\_\_\_\_  
**Applicant Name**



School of Health and Social Care Ethics Committee  
College of Social Science  
Bridge House  
Brayford Pool  
Lincoln  
LN6 7TS

Telephone 01522 837748  
6 August 2015

**RE: Evaluation of the ULHT Rehabilitation Medicine Community Outreach Service**

Dear Ros Kane et al.

Permission is hereby given for the above study, on the basis described in the EA 2 version 2.0 application form and accompanying documents.

On behalf of the committee, I would like to wish you success in your research.  
Regards

Dr Zowie Davy  
Chair Ethics Committee

## Appendix 2: Questionnaire and patient letter

### Rehabilitation Community Outreach Team Patient Experience Survey

#### Information about your situation:

1	Were you a patient of the Rehab Community Outreach Team or the carer of a patient?
	<input type="radio"/> Patient <input type="radio"/> Carer (please complete all questions on the patient's behalf)
2	Where were you seen by the team?
	<input type="radio"/> Home <input type="radio"/> Clinic <input type="radio"/> Mixture of home and clinic
3	When were you <b>first</b> seen by the team?
	<input type="radio"/> Within last 6 months <input type="radio"/> Within last 12 months <input type="radio"/> Over 12 months ago
4	When were you <b>last</b> seen by the team?
	<input type="radio"/> Within last 3 months <input type="radio"/> Within last 6 months <input type="radio"/> Over 6 months ago
5	Did you know of the team <b>before</b> seeing them?
	<input type="radio"/> Yes <input type="radio"/> No

#### Rating your experience:

6	How quickly were you seen after being referred?
	Not quickly at all    1   2   3   4   5   6   7   8   9   10    Very quickly
7	How easy was it to contact the team after you were <b>first</b> seen by them?
	Very difficult    1   2   3   4   5   6   7   8   9   10    Very easy
8	How easy was it to organise seeing the therapists/nurses? (at home or at the clinic)
	Very difficult    1   2   3   4   5   6   7   8   9   10    Very easy
9	Was the pace of treatment too slow, too fast or just right?
	Too slow    1   2   3   4   5   6   7   8   9   10    Too fast
10	How much did you know about what the team does <b>before</b> being seen by them?
	Nothing    1   2   3   4   5   6   7   8   9   10    A lot
11	How well did the therapist/nurse explain to you what the team does?
	Not at all    1   2   3   4   5   6   7   8   9   10    Completely

12	How well informed were you throughout your therapy with this team?											
	<i>Not at all</i>	1	2	3	4	5	6	7	8	9	10	<i>Completely</i>
13	How well did the therapist/nurse explain what you would achieve with the therapy?											
	<i>Not at all</i>	1	2	3	4	5	6	7	8	9	10	<i>Completely</i>
14	How involved did you feel in setting goals for your treatment?											
	<i>Not involved</i>	1	2	3	4	5	6	7	8	9	10	<i>Very involved</i>
15	How well do you feel the therapist/nurse assessed your condition/s?											
	<i>Not at all</i>	1	2	3	4	5	6	7	8	9	10	<i>Completely</i>
16	How well do you feel the service provided fitted around your personal life?											
	<i>Not at all</i>	1	2	3	4	5	6	7	8	9	10	<i>Completely</i>
17	To what level did the service meet your needs?											
	<i>Not at all</i>	1	2	3	4	5	6	7	8	9	10	<i>Completely</i>
18	Were you given the right level of support?											
	<i>Not at all</i>	1	2	3	4	5	6	7	8	9	10	<i>Totally</i>
19	How likely are you to recommend the service to family or friends who need it?											
	<i>Very unlikely</i>	1	2	3	4	5	6	7	8	9	10	<i>Very likely</i>
20	How much of a positive impact has the service had on your life?											
	<i>Not at all</i>	1	2	3	4	5	6	7	8	9	10	<i>Very positive</i>

Details about your experience:

21	Please tell us about any specific issues or problems you experienced with the service?
22	Please tell us what you feel is the most important thing about this service?

If you would like to be contacted regarding any issues you have raised above, please write your name and contact number in the space provided below or call us on 01205 446683.

Name:..... Contact number:.....

**Thank you for taking the time to complete this survey.**

# United Lincolnshire Hospitals

NHS Trust

## **Rehabilitation Medicine Community Outreach Team Patient Experience Survey**

Dear

We are always striving to improve the services we provide the people of Lincolnshire and so we are conducting a survey of peoples' experiences of the Rehabilitation Community Outreach service. By understanding your experiences and views we can ensure that we provide the best possible support and care for people who use the service in the future.

We kindly ask that you take a few moments to answer the attached survey. Most questions ask you to answer using a scale from one to ten. It is completed so that you remain anonymous.

Once completed, please use the stamped addressed envelope to return the survey to David Nelson at the University of Lincoln.

Please refrain from adding your name or any other personal details to the survey itself. We are committed to keeping patient details confidential and want to keep returns anonymous. Your answers will be collated and analysed and then used to make improvements in the service we provide.

If you would be interested in being more fully involved in this review and would be happy to participate in a small focus group to discuss your experience of the service in more detail please complete the attached slip and return this with your survey or call us on 01205 446683

Thank you for taking the time to help, it is greatly appreciated.

Yours sincerely,

Anita Cooper

Clinical Lead – Therapies and Rehabilitation Medicine

**Focus Group**

**I would be interested in taking part in a focus group about the Community Outreach service.**

**My name is**

-----

**My preferred contact details are (telephone / address / email )**

-----

-----

-----

-----

**My preferred location would be (please circle)**

**Lincoln                      Boston                      Grantham                      Louth**

**Please let us know of any special requirements you would have to enable you to attend a focus group**

-----

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-----

-----

**Many thanks**

## Appendix 3: Focus group topic guide

### 1. Information about the service

Do they know who the team are/which members of the team they see?

Is the information provided by the team relevant to them?

Is the information understandable?

### 2. What difference do they feel the team made for them? Quality of life impact

What services have the team provided

Facilitating links to other organisations

Could they give one example of where the team have helped them and explain what a difference this has made?

### 3. Communication with the team

Do they / their carers feel involved in decisions particularly goal setting

Do they feel listened to

Do they feel the things discussed were followed up/actioned

What may help with communication with the team?

### 4. How accessible are the team/ easily contactable?

How do you contact the team?

Are the team respondent?

Any suggestions to make contact with the team easier?

Any changes to the team?

### 5. What could be improved within the team

### 6. What is the value of being seen in their own home? Would they prefer to be seen elsewhere?

Examples of why it is good to be seen in their own home

Or would they prefer to be seen elsewhere - if this is the case why?

Does it depend on the service/treatment being offered

How far would they be prepared to travel

### 7. Anything else to add?

## Appendix 4: Focus group Information sheet and consent form



### Participant Information Sheet Focus Group Participants

#### Evaluation of the United Lincolnshire Hospitals NHS Trust Rehabilitation Medicine Community Outreach Service

We would like to invite you to take part in our evaluation study. Before you decide we would like you to understand why the work is being done and what it would involve for you. One of our team will go through this information sheet with you and answer any questions you have.

This study is being funded as part of the expansion of the service by NHS England Specialised Commissioning Group. The study has been reviewed internally by an expert advisory group within the College of Social Science at the University of Lincoln.

You are being invited to take part in a focus group. A focus group is a small group discussion about a particular subject. During the group discussion you will be asked to talk about your experiences of the Rehabilitation Medicine Community Outreach Service

#### What is the purpose of the study?

To find out your views and experience of the Rehabilitation Medicine Community Outreach Service.

#### Why have I been invited?

You have been invited because of your involvement and experience of using the Rehabilitation Medicine Community Outreach Service.

#### Do I have to take part?

Your participation is entirely voluntary. If you agree to take part, we will ask you to read and complete the consent form and agree to follow the following guidelines:-

- Everyone must treat other members of the group with respect
- Discussion needs to stay on the topic
- People should speak one at a time
- Everyone needs to listen (even when disagreeing)
- People can leave at any time if they don't feel comfortable
- Any responses given should remain confidential and must not be discussed outside of the group



You remain free to withdraw at any time, without giving a reason, by asking to leave the group and will be able to leave the room immediately. Withdrawal from this study will not affect the care you receive in any way. However, if you decide to withdraw, the information you have provided up to the point of withdrawal may still be used in the research.

**What will happen to me if I take part?**

You will be invited to take part in a focus group in a private and convenient location which will last approximately 45-60 minutes. If you do not wish to answer any of the questions then you do not have to.

With your permission the focus group will be digitally recorded and typed up.

**Will my contribution to the study be kept confidential?**

Yes. We will follow ethical and legal practice and all information about you, or that you choose to share, will be anonymised and handled in confidence.

All recordings will be made using digital media files and transcription will also be held on electronic files. All files will be held on an encrypted computer for seven years and then destroyed.

**What will happen to the results?**

The results of the study will take the form of a written report to the funders which will also be widely disseminated using the University of Lincoln Research Repository.

Participants will be kept fully informed of any final outputs from the research and will be offered the opportunity to receive a copy of the final report.

**What if I have complaint or concern?**

If you have any questions about any aspects of this study, please speak to the principal investigator who will do their best to answer your questions. Details are below:

Dr Zowie Davy  
3209 Bridge House  
University of Lincoln  
School of Health & Social Care  
Brayford Pool  
Lincoln  
LN6 7TS

T: 01522 837748  
E: [zdavy@lincoln.ac.uk](mailto:zdavy@lincoln.ac.uk)



**Evaluation of the United Lincolnshire Hospitals NHS Trust  
Rehabilitation Medicine Community Outreach Service**

**PARTICIPANT CONSENT FORM  
Focus Groups**

**Please**

**tick box**

1. I have read and understand the information sheet, for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
3. I understand that all the information I give will be STRICTLY CONFIDENTIAL and I will not reveal the identities of other participants or discuss who made any specific comments during the focus group discussion. ☐
4. I understand that the results from this study will only be presented in anonymous form. ☐
5. I agree to the interview being tape-recorded and/or transcribed. ☐
6. I agree to take part in this study and follow the guidelines given. ☐

Signature (participant): \_\_\_\_\_ (please sign)

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature (researcher): \_\_\_\_\_ (please sign)

Date: \_\_\_\_\_

## **Appendix 5: Stakeholder interview topic guide**

### **Could you tell me a little about your role?**

- Which geographical areas do you cover
- At what stage in a patients care are you involved
- How are people referred to you

### **How do you link with the Rehabilitation Medicine Community Outreach Team?**

- Do you work with them countywide or just one team
- How are patients referred to you by the team / how do you refer people to the team
- How do you Communicate with the team, is there a single point of contact
- Are there any barrier to working together
- What would happen without such a team

### **Are you aware of recent changes to the team?**

- Were you are of this change
- Have you noticed any changes in the number of referrals you receive from the team
- How responsive do you feel the team are to a patient's needs
- Have the changes affected who you deal with within the team, or how you deal with them
- What are the benefits of this increase service to the patients
- (Consultants) Has it affected how quickly patients are discharged from hospital now there is more support in the community
- (Consultants) Has it affected the number of readmissions
- Have you noticed that patients have been maintained in the community where they may previously have been readmitted
- Are you aware how quickly your patients are seen by the team

### **Do you have any examples of good practice with the team?**

### **What further improvements could be made with the resources available?**

- Are there particular things you would like to see the team do differently

### **Can you just summarise your experience of working with the team?**

### **Is there anything else you would like to add?**

## Appendix 6: Stakeholder information sheet and consent form



### Participant Information Sheet Stakeholder Interviews

#### Evaluation of the ULHT Rehabilitation Medicine Community Outreach Service

We would like to invite you to take part in our evaluation study. Before you decide we would like you to understand why the work is being done and what it would involve for you. One of our team will go through this information sheet with you and answer any questions you have.

This study is being funded as part of the expansion of the service by NHS England Specialised Commissioning Group. The study has been reviewed internally by an expert advisory group within the College of Social Science at the University of Lincoln.

You are being invited to take part in an individual interview. During the interview you will be asked to talk about your experiences of the Rehabilitation Medicine Community Outreach Service

#### What is the purpose of the study?

To examine the views of the Rehabilitation Medicine Community Outreach Service.

#### Why have I been invited?

You have been invited because of your involvement and experience of the Rehabilitation Medicine Community Outreach Service.

#### Do I have to take part?

Participation is entirely voluntary. If you agree to take part, we will ask you to read and complete the consent form.

You remain free to withdraw at any time, without giving a reason. Withdrawal from this study will not affect your role in any way. However, if you decide to withdraw, the information you have provided up to the point of withdrawal may still be used in the research.

#### What will happen to me if I take part?

You will be invited to attend one interview which will last approximately 45-60 minutes. It will take place in a private and convenient location with one researcher. If you do not wish to answer any of the questions then you do not have to.

With your permission the interview will be digitally recorded and typed up.

**Will my contribution to the study be kept confidential?**

Yes. We will follow ethical and legal practice and all information about you, or that you choose to share, will be anonymised and handled in confidence.

All recordings will be made using digital media files and transcription will also be held on electronic files. All files will be held on an encrypted computer for seven years and then destroyed.

**What will happen to the results?**

The results of the study will take the form of a written report to the funders which will also be widely disseminated using the University of Lincoln Research Repository.

Participants will be kept fully informed of any final outputs from the research and will be offered the opportunity to receive a copy of the final report.

**What if I have complaint or concern?**

If you have any questions about any aspects of this study, please speak to the principal investigator who will do their best to answer your questions. Details are below:

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E: [zdavy@lincoln.ac.uk](mailto:zdavy@lincoln.ac.uk)



## Evaluation of the ULHT Rehabilitation Medicine Community Outreach Service

### PARTICIPANT CONSENT FORM Stakeholder Interviews

Please tick box

1. I have read and understand the information sheet, for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
3. I understand that all the information I give will be STRICTLY CONFIDENTIAL. ☐
4. I understand that the results from this study will only be presented in anonymous form. ☐
5. I agree to the interview being tape-recorded and/or transcribed. ☐
6. I agree to take part in this study. ☐

Signature (participant): \_\_\_\_\_ (please sign)

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature (researcher): \_\_\_\_\_ (please sign)

Date: \_\_\_\_\_

## Appendix 7: Staff Questionnaire

1. Which of the following are you:-
  - a. Team member prior to changes
  - b. Team member recruited following changes
  - c. Manager/line manager
2. Please outline what positive changes you have noted since the start of the enhanced service
3. Please outline any negative changes/challenges you have noted since the start of the enhanced service
4. Please outline any suggestions for improvement to the current service
5. Please outline any opportunities you can identify for developing the service in the future
6. Please outline what support has been available to you since the changes, and identify anything which could potentially improve this



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